

FILED OCT 4 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **34034**  
Registrar's No. **8875**

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Mo.</b> b. CITY OR TOWN <b>St. Louis</b> c. LENGTH OF STAY (in this place) <b>8 days</b> d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>			
b. CITY (If outside corporate limits, write RURAL and give township) <b>St. Louis</b>				c. CITY OR TOWN <b>St. Louis</b>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Louis Chronic Hosp.</b>				STREET ADDRESS (If rural, give location) <b>2249 02212 Winnebago</b>			
3. NAME OF DECEASED (Type or Print)		a. (First) <b>Joseph</b>		b. (Middle) _____		c. (Last) <b>Renth</b>	
4. DATE OF DEATH		(Month) <b>9</b>		(Day) <b>20</b>		(Year) <b>1957</b>	
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Single</b>		8. DATE OF BIRTH <b>FEB. 25 1873</b>	
9. AGE (In years last birthday) <b>84</b>		IF UNDER 1 YEAR Months _____		IF UNDER 1 YEAR Days _____		IF UNDER 1 YEAR Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>				10b. KIND OF BUSINESS OR INDUSTRY _____			
11. BIRTHPLACE (City and State or Foreign Country) <b>Ill.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U-S-A</b>			
13a. FATHER'S NAME <b>unk.</b>		13b. MOTHER'S MAIDEN NAME <b>unk.</b>		14. NAME OF HUSBAND OR WIFE <b>--</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT'S SIGNATURE OR NAME <b>EDWARD BOCKHORST</b> ADDRESS <b>2212 WINNEBAGO</b>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebral Hemorrhage</b> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Hypertensive Cardiovascular disease</b> DUE TO (c) <b>Dissecting</b> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>443x</b>				INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? <b>2</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT, SUICIDE, HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) _____ (COUNTY) _____ (STATE) _____		21d. TIME OF INJURY (Month) _____ (Day) _____ (Year) _____ (Hour) _____ (Min.) _____	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____					
22. I hereby certify that I attended the deceased from <b>9-12-57</b> , 19____, to <b>9-20-57</b> , 19____, that I last saw the deceased alive on <b>9-20-57</b> , 19____, and that death occurred at <b>1:30pm.</b> , from the causes and on the date stated above.							
23a. SIGNATURE <b>Boze M. Tanaka, M.D.</b> (Degree or title) _____				23b. ADDRESS <b>5800 Arsenal St.</b>		23c. DATE SIGNED <b>9/20/57</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24b. DATE <b>SEPT 23 1957</b>		24c. NAME OF CEMETERY OR CREMATORY <b>SUNSET BURIAL PK.</b>		24d. LOCATION (City, town, or county) (State) <b>ST. LOUIS Mo</b>	
DATE REC'D BY LOCAL REG. <b>SEP 23 57</b>		REGISTER'S SIGNATURE <b>J. Carl Smith M.D.</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Thomas Kuter 2906 Gravier</b> ADDRESS _____			

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER.

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by ..... Student Embalmer No. .... working under my personal supervision.

Student .....  
Signature of Student Embalmer

Signed.....

*Leo J. Bunde*  
Licensed Embalmer No. 398  
P. O. Address *St. Louis, Mo.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.